THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-3209.M5

MDR Tracking Number: M5-04-2891-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 05-03-04.

The IRO reviewed office visits, therapeutic exercises, myofascial release, joint mobilization, manual therapy and neuromuscular re-education rendered from 05-27-03 through 10-17-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 09-13-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Review of CPT code 99212 dates of service 10-20-03 through 11-14-03 (6 DOS) revealed that neither the requestor nor the respondent submitted EOBs. The requestor per Rule 133.307(e)(2)(B) provided convincing evidence of carrier receipt of the request for EOBs. Reimbursement per the Medical Fee Guideline effective 08-01-03 is $278.46 ($37.13 X 125% X 6 DOS). However, the requestor billed $45.41 for each date of service. Reimbursement in the amount of $272.46 ($45.41 X 6 DOS) is recommended.

Review of CPT code 97545-WH (12 units) dates of service 10-20-03 through 11-14-03 (6 DOS) revealed that neither the requestor nor the respondent submitted EOBs. The requestor per Rule 133.307(e)(2)(B) provided convincing evidence of carrier receipt of the request for EOBs. Reimbursement is recommended in the amount of $614.40 ($51.20 X 12 units).

Review of CPT code 97546-WH (30 units) dates of service 10-20-03 through 11-14-03 (6 DOS) revealed that neither the requestor nor the respondent submitted EOBs. The requestor per Rule 133.307(e)(2)(B) provided convincing evidence of carrier receipt of the request for EOBs. Reimbursement is recommended in the amount of $1,536.00

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c), plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 10-20-03 through 11-14-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 18th day of November 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 27, 2004

RE:
MDR Tracking #: M5-04-2891-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Physical Medicine/Rehabilitation reviewer, who is also a chiropractor, and who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Records Submitted for Review

Chart documentation received for review includes approximately four inches of past documentation to include:

- Two reviews by ___
- Notes by ___
- _____ _____ _____ _____ _____ (who appears to be an anesthesiologist)
- EMG/NCV, SSEP testing

- ____ (unknown specialty)
- TWCC forms
- ___ (physical medicine and rehabilitation)
- Injections that have been performed by ____ and his notes from Pain Institute of Texas (unknown specialty, most likely anesthesiologist)

- Notes by ____
- Notes by ____
- ____ who took over care for ___ when he left to serve in the military
- _____ _____ _____ _____ (psychological consult)
- Sundry other information.

Clinical History

This patient has a reported date of injury at age 59 years of age on ___ when he felt a pull in the low back region and developed right hip pain after working and moving some pipes. He is diabetic. His height is 5'6" and weight is 152 pounds. There are reviews present by ____ on 5/29/03 where he states no further conservative care is indicated. A review is once again completed by this chiropractor on 9/3/03 and once again he states continued physical therapy is not necessary and that he does not need any further work hardening or work conditioning.

It would appear that treatment is initiated by a ____ physician, who, 4 days after the DOI, prescribed Skelaxin and Celebrex. He then appears to come under the treatment of ____. Right hip complaints appear to be prominent, as the low back is not really even mentioned. Passive care is initiated for diagnoses of muscle strains, along with a referral for electrodiagnostic testing, for unclear reasons, particularly this early in the course of the work injury. He is referred to ___, anesthesiologist, presumably for medications, on 2/4/03, and complaints at this time are low back, who provides diagnoses of lumbar radiculopathy, facet syndrome, SI joint arthritis, and hip traumatic arthritis. Lortab, Soma, Elavil, and Valium are prescribed, along with a 6 week (18 sessions) course of PT, electrodiagnostic studies, and an MRI. MRI shows multilevel disc bulging at L2-3, L3-4, L4-5, and L5-S1, all felt to be secondary to normal disease of life. Electrodiagnostic studies are performed on 2/20/03, four weeks post-injury, and showed bilateral L5-S1 radiculopathy and peripheral neuropathy. In my opinion, because of the timing, any abnormalities represent pre-existing changes and some probably represent diabetic neuropathy.

On 2/28/03 he is seen by ___ family practice, more PT is ordered, and the claimant is referred to an orthopedic surgeon, and evidently this is accomplished on 4/14/03, with ___. On 4/28/03, the claimant is examined by ___, at the request of TWCC, states the claimant is at MMI, and assigns a 5% WP impairment rating. In May 2003, evidently an ESI is performed. ____ refers the claimant to ___ an internist, for evaluation at the ___. Additional physical therapy and injections are recommended, along with chiropractic manipulations, despite the fact that this has been unsuccessful for three months prior to his examination. For 31 sessions of care from 5/27/03 to 10/8/03, each note, by ___, states that the claimant is "better." If the claimant was better, as listed in all these notes, he would have been recovered.

Multiple notes by ___ from June 2003 to September 2003 are provided, including several that document injections and plans for continued conservative care. There are also notes which suggest that, during the same period of time the claimant is receiving care from ____ ____, Physical Therapist, plans a course of PT. In August, ____ is called to military service, and care passes to ___

family practice. On October 16, 2003, a WHP is initiated. Yet another injection is provided by ___ in November 2003, and a psychological evaluation, ordered by ___, is performed on 12/12/03. A note suggests that the WHP is continuing under ___ direction.

Requested Service(s)

Office visits, therapeutic exercises, myofascial release, joint mobilization, manual therapy, and neuromuscular re-education from 5/27/03 through 10/17/03.

Decision

I agree with the insurance carrier that services billed from 5/27/03 to 10/17/03 were not medically necessary.

Rationale/Basis for Decision

By notes provided on the billing table supplied from 5/27/03-10/20/03 there have been 37 sessions billed of conservative care with therapeutic activities. This type of ongoing care for an injury date of ___ would not be justified according to the US Guidelines for Treatment of Acute Spine Pain who recommend 12 sessions with a maximum of three modalities per session. This prolonged ongoing conservative care is not justified by the records or patient's response. Continued chiropractic and physical medicine modalities are not justified, in the absence of objective improvement in measurable parameters. After review of the extensive amount of records that have been presented, I agree with the evaluation performed by ____, physical medicine and rehabilitation, after the patient had already had a prolonged over-utilization of physical therapy modalities, that this patient was at maximum medical improvement and any ongoing care should have been in the form of a home exercise program only and physician follow-up if necessary. Official Disability Guidelines, Treatment in Workers' Compensation would support a maximum of 18 sessions of physical therapy over a 6 weeks period of time for the diagnosis of lumbar sprain/strain, which would appear to be the operative diagnosis in this claimant. The electrodiagnostic findings represent pre-existing conditions, including diabetic neuropathy. After review of the extensive records, I feel that treatment that has been billed from 5/27/03-10/17/03 for a total of 37 sessions are not supported by the documentation as being medically necessary or reasonable in this patient's treatment care. This amount of conservative sessions with therapeutic activities is way beyond the usual and customary, standard of care, US Guidelines that are in place. This patient did not respond to this ongoing care and continued with complaints. Standard of care would be an initial 12 sessions of a conservative care program, then released to a home exercise program. I would deny billing dates 5/27/03-10/17/03 as over-utilization in conservative care, therapeutic activities and are not standard of care and lack of medical documentation to support this prolonged treatment course.